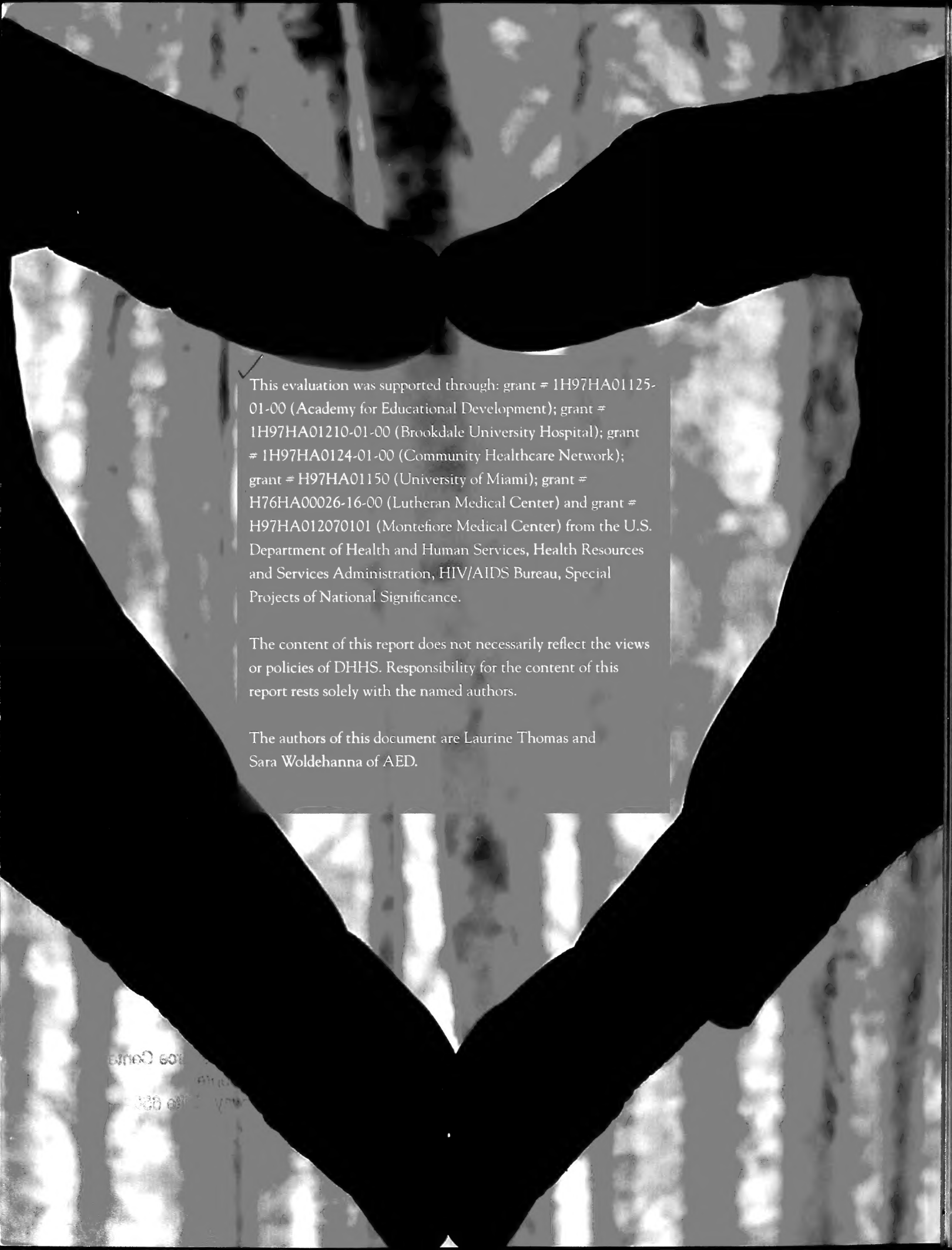
DECEMBER 2007

— MULTI-SITE —

Process Evaluation REPORT

Targeted Peer Support Model
evelopment and Evaluation

Caribbeans Living with HIV/AIDS
(CHIVES) Study



This evaluation was supported through: grant # 1H97HA01125-01-00 (Academy for Educational Development); grant # 1H97HA01210-01-00 (Brookdale University Hospital); grant # 1H97HA0124-01-00 (Community Healthcare Network); grant # H97HA01150 (University of Miami); grant # H76HA00026-16-00 (Lutheran Medical Center) and grant # H97HA012070101 (Montefiore Medical Center) from the U.S. Department of Health and Human Services, Health Resources and Services Administration, HIV/AIDS Bureau, Special Projects of National Significance.

The content of this report does not necessarily reflect the views or policies of DHHS. Responsibility for the content of this report rests solely with the named authors.

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Acknowledgements

The authors wish to acknowledge the contributions of the CHIVES study group, comprised of: Andre Brutus, Adele Flateau, Francois Roche, and Paul Alexis (Brookdale University Hospital and Medical Center, New York, NY); Tracey Wilson and Susan Holman (State University of New York, Downstate Medical Center, New York, NY); Yvette Walker, Steve Hemraj, and Freddy Molano (Community Healthcare Network, New York, NY); Susie Hoffman and Jessica Adams Skinner (New York State Psychiatric Institute at Columbia University Medical Center, New York, NY); Mike Bosket and Christian Richardson (Lutheran Medical Center, New York, NY); Marcia Bayne Smith (Queens College, New York, NY); Alan Rodriguez, Lisa Metsch, Natalie Day Tolentino, Gilbert Saint Jean, and Eddy Jean Baptiste (University of Miami, School of Medicine, Miami, FL); Arthur Blank, Pete Williams, Anitra Pivnick, Elicia Johnson Knox, and Phil Johnson (Montefiore Medical Center, New York, NY); Susan Middlestadt (Indiana University, Bloomington, IN); Adan Cajina, Alice Kroliczak, and Moses Pounds (U.S. Department of Health and Human Services, Health Resources and Services Administration, HIV/AIDS Bureau, Rockville, MD).

The authors also wish to acknowledge the assistance of Pat Nalls and the staff of the Women's Collective, Washington, DC; Michele Shedlin, PhD, University of Texas at El Paso, Department of Health Promotion; and Daniel Sheahan of AED for his role as CHIVES editor.

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I. Rationale for the CHIVES[1] Multi-site Process Evaluation

The Special Projects of National Significance (SPNS) Targeted Peer Support Model Development for Caribbeans Living with HIV/AIDS Demonstration Project[2] is a five- site initiative funded by the Health Resources and Services Administration's HIV/AIDS Bureau (HAB). Launched in 2003, the project centers on creating models of peer support for HIV-positive Caribbean immigrants residing in the United States in order to increase their knowledge of HIV infection, their understanding of HIV treatment options and the service delivery system, and their timely use of appropriate HIV medical care and ancillary services.

The CHIVES multi-site process evaluation analyzes the early development and actual implementation of the program, and assesses whether interventions were implemented as planned and whether expected output was actually produced. It provides information that will be essential for the future replication of the intervention and documents lessons learned. This study complements the multi-site outcome evaluation and employs the same instruments across all five sites so that the process data may be compared across the sites. Process evaluation can provide answers to three important questions:

- Why was the Demonstration developed?
- How did the interventions at each site operate?
- Did the interventions operate as intended?

The process evaluation includes peer promoters' perceptions rather than data obtained directly from clients and potential clients, since the latter are the focus of the outcome evaluation. This approach has yielded valid data since CHIVES is a peer-based intervention, and the peer promoters are themselves members of the population from which clients are selected.

[1] CHIVES is the acronym for Caribbean HIV Evaluation Support.
[2] Hereafter referred to as the CHIVES Demonstration.

a. Methodology

Given the complexity of the CHIVES Demonstration, AED employed a mixed-methods approach designed to minimize the burden of data collection on the sites and the resources expended on the evaluation effort. AED utilized document reviews, observational studies, encounter logs, in-depth interviews, and group interviews. AED collected data only from project staff, not from clients.

Document Review

AED asked the sites to submit several site documents, including:

- Site research design;
- Site intervention manuals, including outreach protocols; and
- Site peer promoter training manuals.

The document review informed assessments of the fidelity of the intervention; the frequency, nature, and rationale for changes in the implementation of the intervention; the activities and resources expended in the evaluation; and the roles and responsibilities of all involved.

Observational Studies

AED observed key activities and locations during the course of visits to each site. These processes included staff meetings with and without peer promoters, outreach activities, service-delivery locations, intake and enrollment activities, peer promoter and client interactions, and tracking activities. AED developed a standard list of contexts and activities to observe, and common guides for the observations to ensure uniformity in the data-collection effort.

Encounter Logs

Some data were drawn from peer-encounter forms that the sites submitted to AED. These forms document each encounter that a peer promoter has with a client and record the length and setting of each interaction, as well as the nature of the encounter in detail.

Thus, the form provides both qualitative and quantitative data on the encounters. The evaluators used these data to respond to questions about the intervention delivery.

FIGURE 1

Brookdale CHIVES Intervention

Institutional Context:
The Treatment for Life Clinic, the only AIDS designated center in Brooklyn, NY.

Staffing

a. Principal Investigator-overall direction
- *Delivered primary care to most of the clients*

b. Health educator- trained and supervised peer-promoters
- *Day-to-day management of the program*

c. Program coordinator
- *Day-to-day management of the program*

d. Administrative coordinator
- *Day-to-day administration of the program*

Partners

a. Local Haitian TV and radio stations
- *Client referrals*

b. Faith-based institutions
- *Client referrals*

c. Local Haitian physicians
- *Client referrals*

d. Local testing and counseling centers
- *Client referrals*

7 Peer Promoters

Selected from among the TLC patients who were the most adherent to their medical regimen. Conducted outreach, client follow-up and delivered the intervention—6 monthly one-on-one sessions with clients and 6 two hour group sessions, provided referrals and escort to healthcare and other appointments as well as reminder calls.

In-depth Interviews

AED conducted telephone and in-person interviews with site staff, including project principal investigators and peer promoters, to obtain additional insights that would complement those gained through the document review and analysis of peer-encounter forms.

Group Interviews

AED conducted semi-structured group discussions utilizing a visual mobilization technique with peer promoters and other outreach staff regarding their involvement in key intervention processes. Visual mobilization is a participatory data-collection method that involves group discussion along with spatial exercises that assist participants in identifying the common themes in the discussion. This methodology engages participants in a non-threatening manner to respond to research questions, group similar or like responses, analyze the responses by developing a theme for each major group of responses, discuss the results with a focus on identifying trends and patterns, and issue recommendations. For example, in a discussion of successful outreach techniques, visual mobilization with the peer promoters assisted the peers to group similar outreach techniques and prioritize their relative importance at each site.

The evaluators collected data at various points throughout the project year. They conducted annual visits to each site. They also collected data from selected project staff at the annual all-site meetings and via telephone calls.

b. Data Analysis

AED used content analysis to analyze the data collected via the various methods outlined above. Analysis was iterative, as is appropriate for a study that is primarily qualitative in nature. After each data-collection activity, AED debriefed with the participants to interpret the data and situate the meaning within the context of the overall project. AED also convened sessions during annual all-site meetings to discuss the process data and arrive at a shared understanding of the findings. Content analysis revealed the factors that had the greatest impact on the operation of the intervention at each site.

II. Why Was the Program Developed?

HIV/AIDS has affected all ethnic groups worldwide, but it has been particularly devastating in the Caribbean community. With a prevalence rate of 2.3 percent, HIV infection rates in the Caribbean are the highest in the world outside of Africa.[3] According to a Joint United Nations Programme on HIV/AIDS (UNAIDS) report, *"among the factors helping drive the spread of HIV in the region overall is a combination of unequal socioeconomic development and high population mobility. Unless overcome, the economic difficulties plaguing several countries in the region are likely to further entrench a socioeconomic context that can facilitate the epidemic's spread."*[4]

Caribbean migration and immigration have an impact on the United States. The latest Census figures indicate that 2.8 million of the 14.5 million Latin American-born individuals residing in the United States are from the Caribbean.[5] Given the relative lack of HIV testing and treatment services in the Caribbean, many who seek to immigrate to the United States may not be aware of their serostatus. For those who are aware that they are seropositive, there is little incentive to disclose this prior to coming to the United States—since individuals infected with HIV are barred from obtaining a visa to enter the United States.[6] Based on such compelling facts, as well as data from focus group research commissioned by the U.S. Department of Health and Human Services (DHHS) Health Resources and Services Administration (HRSA) HIV/AIDS Bureau (HAB) Special Projects of National Significance (SPNS), to better understand the impact of HIV/AIDS within the Caribbean community, SPNS decided to support the implementation of four peer-support Demonstration sites in New York City (Community Health Care Network [CHN]), Montefiore Medical Center (Montefiore), Brookdale University Hospital and Medical Center (Brookdale), and Lutheran Medical Center/Caribbean Women's Health Association (Lutheran), as well as one site in Miami (the University of Miami [Miami]). The Academy for Educational Development (AED) was selected to run the evaluation and technical assistance center that supported the sites and to conduct both the multi-site process and outcomes evaluation. The Demonstration commenced in September 2003 and concluded in August 2007.

[3] UNAIDS. (2006). *Fact Sheet on the Caribbean*. Retrieved May 2006, from http://data.unaids.org/pub/GlobalReport/2006/200605-fs_caribbean_en.pdf

[4] UNAIDS/World Health Organization (WHO). (2002). *AIDS Epidemic Update: December 2002*. UNAIDS/WHO: Geneva.

[5] Schmidley, A.D. (2001). Profile of the foreign-born population in the United States: 2000, *Current Population Reports, Series P23-206*. U.S. Census Bureau. Washington, DC: U.S. Government Printing Office.

[6] Voelker, R. (2001). HIV/AIDS in the Caribbean: Big problems in small islands. *Journal of the American Medical Association, 285*(23), 2961-2963.

III. How Did the Program Operate?

a. Requirements of the Demonstration

To be eligible, applicants had to be public organizations or non-profit private organizations that were already providing care to HIV-positive Caribbean[7] immigrants, and would also be able to track clients enrolled in the Demonstration. The original program guidance stated that each grantee should focus on one Caribbean population, and provide justification if a second population was being targeted. However, due to problems encountered in recruiting sufficient numbers of clients belonging to only one Caribbean population within each site's recruitment area, this guideline was later changed to allow the sites to recruit from as many Caribbean countries as they wished—provided they had the culturally appropriate staff to serve the newly recruited clients.

In addition, applicants to the Demonstration had to agree to develop, conduct, and evaluate a theory-based peer-support intervention designed to increase: (1) knowledge of HIV infection; (2) understanding of HIV treatment options and the service delivery system and; (3) the timely use of appropriate HIV medical care and ancillary services. SPNS defined *"appropriate medical care"* as care that was consistent with the most recent Department of Health and Human Services (DHHS) Public Health Service HIV treatment guidelines, in which a patient was to remain connected to care and receive care at successive visits. [8] The funder defined ancillary services as supportive services found to facilitate entry and retention in care, such as housing assistance, food, transportation, mental health, and substance abuse treatment. [9]

The CHIVES Demonstration was funded for four years. Year I funding supported the design and development of the peer-support interventions proposed by the sites, as well as the recruitment and training of the peer promoters who would work at each site. Once the interventions were approved by SPNS, the sites switched to recruitment and implementation in Year II. Recruitment terminated at the end of Year III and clients were transitioned out of the program starting no later than the spring of project Year IV.

[7]SPNS defined the Caribbean as follows: Anguilla, Antigua, Aruba, the Bahamas, Barbados, Barbuda, the British Virgin Islands, the Cayman Islands, Dominica, the Dominican Republic, French Guiana, Grenada, Guadeloupe, Guyana, Haiti, Jamaica, Martinique, Montserrat, Netherlands Antilles, Puerto Rico, Saint Kitts and Nevis, Saint Lucia, Saint Vincent and the Grenadines, Suriname, Trinidad and Tobago, the Turks and Caicos Islands, and the United States Virgin Islands.

[8]Panel on Clinical Practices for Treatment of HIV Infection. (2003). *Guidelines for the Use of Antiretroviral Agents in HIV-1-Infected Adults and Adolescents, July 14, 2003.* U.S. Department of Health and Human Services: Washington, DC.

[9]Conviser, R. & Pounds, M.B. (2002). Background for the studies on ancillary services and primary care use. AIDS Care, 14(Suppl. 1), S7-14.

Funded sites were required to assist SPNS efforts to replicate successful programs by carefully documenting the design and implementation of their projects. Sites were also expected to participate in a standardized multi-site evaluation of the Demonstration conducted by the CHIVES Evaluation Center, as well as conduct their own local evaluation of their intervention. As part of this effort, sites had to obtain, manage, and submit evaluation data (including data from client medical records) in an electronic format to the Demonstration's Evaluation Center. Sites were also expected to recruit sufficient clients to form intervention and comparison groups; random assignment was strongly encouraged, but not mandated.

In 2003, as a result of its objective review committee process, SPNS awarded grants to five sites to design and implement peer support interventions for the HIV-positive Caribbean populations in their respective communities. To recap, four of the sites were in New York: Brookdale, CHN, Lutheran, and Montefiore; the fifth was in Miami. The sites employed various approaches to developing their interventions, which also varied in length and content, as collectively indicated in Table 1. Figures 1, 3-6 provide an overview of each individual site and its operations.

Content of the CHIVES Interventions

Duration	Brookdale 6 months	CHN 6 months	Lutheran 3 months	Miami 3 months	Montefiore 12 months
Session I	Introduction to Staff	HIV/AIDS 101	HIV 101	Building the Relationship	Goals of the Program
Session II	Increase Knowledge about HIV	Protective Behavior	Harm Reduction	Emphasizing Personal Strengths	HIV 101
Session III	Safe Sex: Do Condoms Work?	Navigating the Healthcare System: Communication	Communication and Skill Building	Learning to Make Contacts	HIV 101, Expanded Hepatitis: A, B, C
Session IV	Immune Defenses: Why Safe Sex is Important	Navigating the Health System: Accessing Healthcare	Building Networks	Reviewing Progress	Determinants of Health: Lifestyle and Behavior, Social Support
Session V	Impact of HIV on Haitians	Coping Skills and Living Positively	Understanding Lab Results and Treatment Options	Completing the Work	Concrete Services: Housing, Immigration, Transportation, Childcare
Session VI	HIPAA Privacy, Notifying Your Partner, Confidentiality	Maintaining Physical and Mental Health	HIV/AIDS Resources for Caribbean People		Healthcare Systems: Making Appointments, Talking with Your Doctor, Know Your Medications
Session VII	Opportunistic Infections, Importance of Seeking Medical Care, How to Overcome Cultural, Religious, Language Barriers		Identifying Ways to Reduce Barriers		Learning Styles
Session VIII	Where to Go to Seek Medical Care, How to Communicate with Your Doctor		Create a Health Action Plan		Stages of Change
Session IX	Emotional Support				Health Beliefs and Attitudes
Session X	Enhancing Family Support Systems				Nutrition
Session XI	How to Combat Stigma				Fears, Concerns, Issues, Racism, Sexuality
Session XII	Structural Support (Housing, Substance Abuse, Transportation, Childcare, Language Barriers, Domestic Violence, Preventing Suicide)				Stress, Coping, Substance Abuse
Session XIII					Social Networks and Social Support
Session XIV					Religion and Spirituality

b. *Recruitment and Engagement of Peer Promoters*

Peer promoters were the key staff in this Demonstration. As reflected in Figures 1, 3-6, the number of peer promoters at each site varied, as did how they were recruited and their responsibilities. HRSA's guidance stated that peer promoters had to be HIV-positive persons of Caribbean origin who reside or work in the community in which the clients they would be recruiting resided. In addition, teams established criteria that would ensure the effectiveness of the peer promoters within the specific context. Common peer promoter selection criteria across the sites included: adherence to medical regimen, ability to navigate the HIV primary care system, willingness and ability to maintain client confidentiality, and membership within the target community.

c. *Peer Promoters' Roles, Responsibilities, and Compensation*

The Demonstration set forth some guidelines regarding the peer promoters and the services they would offer. The guidelines on intervention content stated that applicants could use one-on-one and/or group discussions between a client and a trained peer promoter who had to be a member of the client's social network. SPNS mandated that peer promoter client interactions center on culturally appropriate HIV education, social support, health promotion, and encouragement to use medical care and referrals to ancillary services. Peer promoters' services had to constitute new or enhanced services for clients, and it was expected that peer promoters would meet with clients at least weekly.

Figures 1, 3-6, present the responsibilities of peer promoters and the format and frequency of their mandated client meetings. In all cases, peer promoters met clients more often than was required by the intervention curriculum of the site in question, as seen in Table 2 on p. 15. What happened during these encounters, as well as during the mandated sessions, was recorded by the peer promoters in the CHIVES Multi-site Peer Promoter Encounter Form.


CHIVES

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TABLE 2

Client Encounter Statistics

	Number of treatment clients	Treatment clients with at least one encounter (percent)	Total number of encounters	Average number of encounters per client	Average duration of encounter per client per encounter (hour)	Average duration of encounter per client per encounter (a) (hour)	Clients that had at least one one-on-one peer encounter (a) (percent)	Clients that had at least one group peer encounter (a) (percent)
Brookdale	56	76.8	340	6.07	0.94	1.22	100	44.2
CHN	43	95.3	312	7.26	1.38	1.45	97.6	53.7
Lutheran	23	73.9	104	4.52	0.70	0.95	100	0
Miami	42	100	118	2.81	2.42	2.42	97.6	66.7
Montefiore	29	100	2914	100.48	0.54	0.54	100	79.3

a: including only clients that had an encounter

Peer Promoter Compensation

One of the main determinants of peer promoters' compensation was the sites' perception of how the proposed payment would jeopardize the peer promoters' Medicaid benefits by raising their income above the state-mandated threshold for Ryan White HIV/AIDS Program participants. Besides making it financially unattractive to work as a peer promoter, the problem with Medicaid benefits also meant that sites had no incentive to give peer promoters raises or more work hours. Sites used different approaches to address this dilemma.

Montefiore always kept a complement of four peer promoters. Initially the site had budgeted for four full-time peer promoters who would receive a salary along with benefits. However, mounting project expenses forced the site to offer full-time employment to just two peer promoters, while the other two received a stipend so as not to jeopardize their public assistance. CHN limited its peer promoters to working 20 hours per week in order to *"allow"* them to keep their Medicaid benefits. Nevertheless, one peer promoter quit after receiving her first pay check because her earnings reduced her food stamps to $1. From the outset, Brookdale was also concerned that it could not pay peer promoters more than $8,400 annually without causing them to lose their Medicaid benefits. Therefore, Brookdale reported that after its peer promoters reached the Medicaid earning threshold, some continued to *"work out of the goodness of their heart."* These peer promoters worked 14 hours a week, yet only made $5,000 per year. Furthermore, their wages were deducted from their benefits. Those not receiving state benefits could have worked more hours, but in order to have a standard amount of hours across the peer promoter group, the site did not allow anyone to work more than 14 hours per week. As a result, three of the original 10 peer promoters left the project.

Lutheran was also not able to resolve the problem of low compensation. Early in Demonstration Year

II, three of the site's six peer promoters found permanent employment (paying living wages) and left the program. Lutheran paid its peer promoters in one-hour blocks of time, with the amount of time the peer promoters worked dependent on the number of clients they had. The program coordinator estimated that each peer promoter worked four to six hours a week, with each hour representing a client encounter.

Miami, as a contrasting case, had originally proposed to have four part-time peer promoters. However, given the lower-than-anticipated recruitment figures and the desire to provide the peer promoters with benefits and a reasonable salary, the site made the decision to hire two full-time peer promoters. The principal investigator noted that he tried to make the job as appealing as possible within the university's framework and to compensate the peer promoters to the greatest extent possible. The supervisor added that the requirements stipulated by the project (Haitians with legal immigration status and other qualifications) meant a small pool from which to draw peer promoters. The pool shrunk further due to the low salary. Since the Miami peer promoters received benefits, the problem faced at other sites about how to compensate them without jeopardizing their Medicaid benefits was not an issue here. Miami also eventually gave peer promoters an annual cost of living increase, plus an additional salary adjustment that was more than what the University normally allowed.

Trends in Peer Promoter/Client Encounters

FIGURE 2

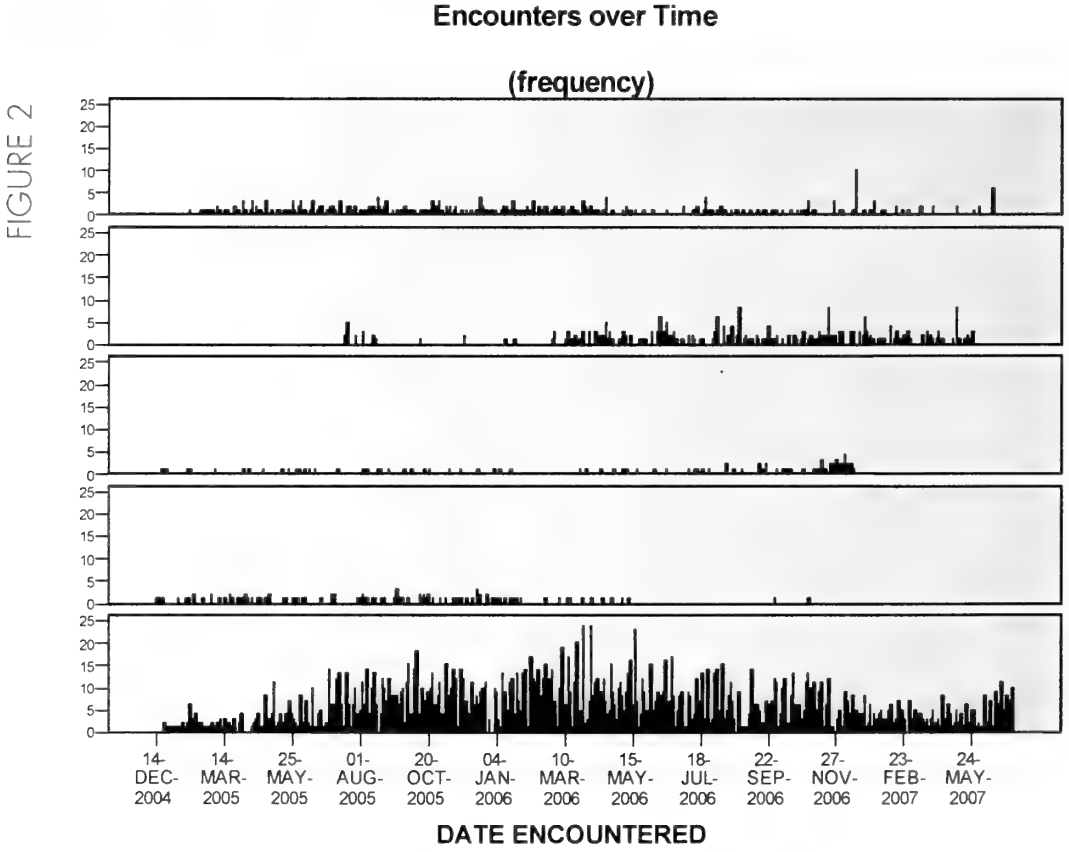

FIGURE 3

CHN
CHIVES Intervention

Institutional Context:
A non-profit 501(c)3 organization comprising 12 community health centers, three medical mobile units, and one satellite facility.

Staffing

a. Principal Investigator
- *Overall project direction*

b. Senior Manager
- *Overall project direction*

c. Program Manager
- *Day-to-day operation and peer-promoter supervision*
- *Outreach, client follow-up*

Partners

a. Local organizations that provided ancillary services that CHN does not, such as housing, immigration, and food pantry.

3 Peer Promoters

Recruited from among existing CHN peer programs and also from patients on the CHN caseload. Later, due to staff turnover, it found peers through referrals from other peer-promoters, and also from clients.
Conducted outreach, client follow-up and delivered the intervention – 12 weekly one-on-one sessions and six 90 minute group sessions, provided referrals and escort to healthcare and other appointments as well as reminder calls.

d. Peer Promoters' Training and Support

Table 3 summarizes the topics that were covered in multi-site and site-specific trainings, respectively. Peer promoters were required to attend the multi-site training, and the sites were required to develop site-specific training that aligned with the content and format of their interventions.

e. Assignment of Clients to Peer Promoters

The sites had different strategies for assigning clients to peer promoters. At Brookdale, the program coordinator—in consultation with the rest of the team (including peer promoters)—assigned clients to peer promoters. Clients were offered their choice of peer promoter. Gender concordance was neither promoted by the site nor was it always requested by clients. All clients met all of the peer promoters, but clients were assigned to a single peer promoter. All the same, the other peer promoters were always ready to assist if a client's assigned peer was not available. The program coordinator and the peers' supervisor periodically reviewed the assignments and changed them if clients did not appear to be making progress.

Content of Site-Specific Peer Promoter Trainings

Multi-Site Training	Brookdale	CHN	Lutheran	Miami	Montéfiore
3 days	43.5 hours	12 weeks	12 weeks	1 week, plus 3 months for the Florida Dept. of Health courses	50 weeks
Role of the Peer Promoter	Introduction to the Project	Introduction/Confidentiality	Overview of HIV/AIDS	Peer Promoter Skills	Introduction to the Project
Overview of Workshop	Overview of HIV/AIDS	Overview of HIV/AIDS	Behavioral Counseling	Study Procedures	HIV/AIDS 101
Critical HIV/AIDS information	HIV Testing	Group Process	Behavioral Counseling for PLWHA	Giving Appropriate Referrals	Case Management and Access to Healthcare
Maintaining privacy and confidentiality	Knowledge about Treatment	Male and Female Condom Usage	Reducing the Risk and Harm of HIV	Florida Department of Health HIV/AIDS 104	Clinical Session HIV/AIDS 101 Expanded
Building Rapport and Trust While Maintaining Appropriate Boundaries	Knowledge about Navigating the System	Creating a Therapeutic Environment	HIV Confidentiality Law	Florida Department of Health HIV/AIDS 501	Special Needs of Immigrants, Ex-Offenders, Women, Men, Adolescents and LGBT
Dealing with Stigma and Fear	Communication Skills	Crisis Management and Difficult Situations	Stigma Associated with HIV/AIDS		Health Beliefs, Attitudes, Behaviors
Helping Clients Get Quality Assistance for Life Issues	Self-Efficacy for Planning and Follow-Through	Helping Clients to Seek Help and Social Support	Case Management		Spirituality
Seeking care and making other changes	Self-Efficacy to Cope with Disease	Understanding Pre and Post Test Counseling	How to Improve Communication Skills		Nutrition
Helping Clients Negotiate with Health Care Providers	Presentation Skills	Boundaries, Limit Setting and Referrals			Fears, Concerns, Issues, Stigma
Getting Support Through Resources	Reducing Impact of Emotional Problems	Communication			Stress and Coping
Applying the Workshop to Your Program	Social Support	Helping Clients Cope with Stigma			Culture
	Stigma	Dealing with Stress and Burnout			Family Issues
	Structural/Logistical Support	Administrative Tasks			Clinical Session HIV/AIDS 101 Expanded
		Outreach Techniques			Clinical and Medical Issues Explored
		Delivering the Intervention			Course Evaluation and Certification

At Miami, clients were randomly assigned to peer promoters. Since both of Miami's peer promoters were female, gender concordance for male clients was not an option. Clients at Lutheran were asked for their preferences with respect to the gender, country of origin, and sexual orientation of their peer promoter. According to the Lutheran peer promoters, once an assignment was made, clients often saw other peer promoters. If a peer promoter was not available, the outreach worker (who is HIV positive) would meet with the client—although this interaction would not count as a regular session.

CHN changed its assignment policy in the fall of 2005; prior to that, all peer promoters saw all clients. However, in order to improve accountability and fidelity to the intervention, the change was made so that each newly enrolled client was given the opportunity to meet all of the peer promoters prior to being assigned to one. Assignments were made randomly for the most part; except in instances where a client requested gender concordance.

At Montefiore, once a client was enrolled, the peer promoter supervisor would consider the characteristics of the client and his or her stated needs, and use this assessment to assign the client to a peer. The principal investigator met weekly with the entire team to review, among other things, peer promoter caseloads so that none were overburdened. The aim was to help peer promoters strike a balance between outreach and client service responsibilities.

f. Other Staffing Beyond Peer Promoters

While the peer promoters were central to the proper functioning of the interventions, other staff were needed for leadership and support roles. HRSA allowed sites to develop their own staffing models, based on their approach to the intervention, prior experience, and institutional requirements. The make-up of the core team at each site is displayed in Figures 1, 3-6. Although they made an important contribution to the Demonstration, team members who were responsible for research—such as the evaluator and the data manager—are not included in the figures. The research interviewers are mentioned, however, because their role partly involved locating clients for follow-up interviews. As a result, the research interviewers were often in a position to persuade clients who had dropped out of the intervention to return or to persuade those who were considering dropping out to remain.

g. Sites' Partners

The sites engaged a variety of partners in order to link clients to ancillary services and to assist in outreach and recruitment efforts. In some cases, new partnerships were forged as a result of the CHIVES program; for the most part, the sites relied on existing relationships. For example, Montefiore's medical director had relationships with both the Montefiore AIDS Center and the New York City Department of Health (DOH) testing site that pre-dated the Demonstration—so he used these to forge partnerships with the project. Brookdale established mutually beneficial referral linkages with local community-based organizations, whereby they referred clients to the intervention and Brookdale referred clients back to the organizations for ancillary services. Miami reported that HIV services in the county were very fragmented and that there is a lot of guarding of one's turf; as a result, it was difficult to recruit external partners. The external partners that Miami had were all members of the adult HIV clinic's community advisory board. Internal to the Hospital, Miami was able to enlist the aid of case managers by stressing that CHIVES actually decreased admissions and increased revenue by linking patients to primary care, while helping case managers do their jobs. The Miami team also pointed out to case managers that CHIVES helped patients prepare to meet with case managers, for example, by ensuring that they had the necessary documents when they went to meet with them. CHN signed a memorandum of understanding with those agencies that held promise of being good sources of client referrals. In return for client referrals, CHN referred clients to the agencies to receive services unavailable at CHN.

h. Transitioning Clients

The CHIVES interventions ranged in length from a minimum of three months (Miami) to a maximum of 12 months (Montefiore). Once the intervention period ended, and certainly when the CHIVES funding came to an end, clients were expected to transition. Hopefully at this point they were all equipped, as a result of the intervention, to navigate the primary and ancillary care systems, respectively. However, given the close bonds forged between some clients and their respective peer promoters, what would happen if a client remained dependent on his/her peer promoter when the intervention ended? The sites had varying experiences with transitioning clients to the next level. This task was the responsibility of the peer promoters and their responses are noted in Table 4 on the following page.

TABLE 4

Transitioning to Independence

How did sites aid clients to be independent at the conclusion of the intervention?				
Brookdale	**CHN**	**Lutheran**	**Miami**	**Montefiore**
Brookdale's peer promoters acknowledged that clients who did not speak English might face problems with being dependent. However, the team said that even clients who were recent immigrants were eager to do for themselves. They explained this finding as a function of the Haitian mentality that stresses preserving privacy and confidentiality. "While clients appreciate the help they are getting, as soon as they know the basics they want to handle things themselves. Also it's a pride issue—when someone is helping you too much then it's like you are a child." – Brookdale Peer Promoter	CHN linked clients to its Ryan White Title I case management program as well as to agencies and support groups while they were enrolled in the intervention. Thus, once the six month intervention ended, clients were aware of resources they could tap into as any needs arose. Clients formed their own social networks as a result of attending the intervention groups and these remained a source of support once the intervention concluded.	Lutheran's peer promoters listed the following strategies as tools they employed to aid their clients towards independence: Build client confidence and self-esteem. Emphasize that the client can have a regular life. Use the peer promoter's own life as an example of what can be. These strategies were employed at every encounter so that at the conclusion of the 90-day period, none of the clients were unable or unwilling to move on.	The Miami peer promoters said that they did not have a problem with clients being dependent because the expectation that the client will be independent after 90 days is laid out very clearly in the initial contact between the peer promoter and the client. Once the 90-day period comes to a close, the clients are referred to hospital case managers or a local agency that can help them with whatever additional problems they may have.	"From the start we make it clear that the expectation is that they can do it for themselves in the future. … draw the line. Tell them you have an appointment, now you need to keep it." -- Montefiore Peer Promoter The facilitated group discussions promoted information exchange and created a community of support among the clients. In addition, once clients ended the program, they could continue to be part of peer support groups run by the Women's Center.

FIGURE 4

Lutheran/ CWHA CHIVES Intervention

Institutional Context:
Community health network - concentrates on serving southwest Brooklyn.

Staffing

a. Principal Investigator
- *Overall project direction*

b. Outreach Worker
- *Outreach and follow-up*

c. Project Coordinator
- *Trained and supervised peer-promoters*
- *Day-to-day administration*

Partners

a. Caribbean Women's Health Association
- *Assisted with outreach*

b. Local Caribbean media outlets
- *Assisted with outreach*

c. Small businesses catering to Caribbeans
- *Assisted with outreach*

c. Local health and human service providers
- *Ancillary care not available at Lutheran*

3 Peer Promoters

Recruited from patients in the Lutheran clinic network. Clinical staff recommended patients who fit the eligibility criteria, and who had the stamina and personality to do the job. Delivered the intervention–8 weekly one hour, one-on-one sessions; provided referrals and escort to healthcare and other appointments as well as reminder calls.

IV. Did the Program Operate as Intended?

All sites had measures in place that were designed to ensure fidelity to the intervention. In addition to regular team meetings, measures included regular meetings where the peer promoters' supervisor had the opportunity to review their activities. A peer promoter client encounter-tracking form that the CHIVES Technical Assistance and Evaluation Center developed was also used to assess fidelity. In addition, during Year I of the intervention, each site was required to develop a manual that outlined the curriculum and the policies and procedures that staff-members were to observe. In some cases, the manual also served as the training guide for the peer promoters.

Each manual outlined what staff should do in the event of an emergency involving themselves, other staff, and/or clients. The manuals set forth the guidelines for conducting outreach and recruitment, including providing assurance of the voluntary and confidential nature of participation and obtaining informed consent. The research protocols were also included, as well as the steps staff should take in the event that they encountered problems while trying to follow them.

The manual contained guidance on the intervention delivery, including the mandated frequency and nature of client contacts; the topics to be covered; and the procedure for documenting contacts. All manuals were required to include sections on the legal requirement to observe the Health Insurance Portability and Accountability Act (HIPAA), state and institutional privacy regulations, and the penalties for not doing so. The manual also covered staff's obligation to report certain types of abuse that might have been experienced by clients, and the procedure for making a report. In addition, the manuals described the process for referring patients for ancillary and other services—and in some cases, included a list of referral agencies. Many of the manuals went into the specifics of the duration of formal client contacts that were part of the intervention curriculum, as well as the rules guiding informal contacts such as telephone calls. These rules included a discussion of maintaining appropriate boundaries with clients during informal contacts, such as after-hours telephone calls, and the procedures to follow if problems were encountered in this area. Finally, guidance was provided on how to assist clients to transition out of the intervention.

The manuals addressed team organization, including supervisory and reporting structures, leave and sick time policies, and reasons for termination from the project. In some cases, manuals detailed trainings and other meetings that staff would be required to attend, and resources that were available to provide support to staff (particularly the peer promoters).

The biggest departure from the original protocols was due to the *problems with outreach* across all five sites. Six months into the client recruitment period, it became clear that recruitment figures were not as high as anticipated. This continued to be the case until recruitment concluded (Table 5).

TABLE 5

Projected and Actual Enrollments

	Brookdale	CHN	Lutheran	Miami	Montefiore
Target Enrollment Numbers	200	152	140	200	70
Final Enrollment (percent of target)	88 (44%)	75 (49.3%)	39 (27.9%)	87 (43.5%)	55 (78.6%)

As a result, HRSA allowed the sites to expand their outreach efforts to people who had emigrated from countries beyond those originally proposed. Three of the sites that were serving English-speaking immigrants—CHN, Lutheran, and Montefiore—chose to expand outreach to immigrants from numerous additional English-speaking countries. Lutheran also included English-speaking Puerto Ricans. Brookdale and Miami served Haitians and chose not to expand outreach because their interventions were delivered in Kreyol, which is spoken only in Haiti.


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In other cases, when fidelity was not maintained, it was due to a host of factors—some outside the site's control. For example, Montefiore originally proposed a 36-month intervention. However, when informed that such a time-frame would not be feasible given the multi-site evaluation requirements of the Demonstration, the site agreed to reduce the length of its intervention to 12 months. Then, prior to the start of the intervention, and in response to protests from the churches, Montefiore changed the way it proposed to randomize clients. Instead of the unit of randomization being the individual client, at the churches' recommendation, the site changed the unit to individual churches—so that eligible members of the same congregation were all assigned to either the treatment or the comparison group. This change was advocated to avoid conflicts that might have arisen within congregations if some members received treatment and others did not. Besides expanding the number of countries from which it recruited clients, Montefiore also expanded its outreach effort to include referrals from the Montefiore AIDS Center and other clinics in the vicinity. This change was made in May 2005, in response to low enrollment. At the same time, Miami proposed to conduct outreach in the community and to accept referrals from local clinics; however, arranging these referral networks proved to be unexpectedly complicated—so this proposed plan was never implemented.

Other than the aforementioned changes, which were imposed from outside, Montefiore maintained fidelity to its intervention. Team members explained that they were able to adhere quite strictly to the model; because, as a team, they spent weeks and months identifying, discussing, and refining the goals of the program. At the end of this process, everyone had the same clear perception of what the program was intended to do.

Some changes to the intervention were a result of client factors. Lutheran's peer promoters reported that they tried to meet with clients at least once a week, and were usually able to cover the intervention curriculum in 12 weeks—four weeks longer than originally planned. The extra time was needed because of the variety of life issues faced by the clients, as well as problems in coordinating the schedules of the peer promoters and the clients. Some clients returned to the Caribbean during the intervention. Others were grappling with serious problems—such as unemployment or homelessness—that made them unable to meet with the peer promoters. Since Lutheran's peer promoters were part-time employees, most had other jobs. Consequently, at times, their schedules and those of the clients conflicted, and encounters could not take place.

Problems with outreach and staffing impacted fidelity to the intervention at CHN. Four months into the intervention, only four people were enrolled in the treatment group. This low number prevented the site from implementing the intervention, which was structured to begin with group sessions. While waiting for the numbers to increase, the peer promoters conducted one-on-one sessions with the clients. Subsequently, turnover among the peer promoters prevented the group sessions from being held with regularity until spring 2006, when the full complement of staff was on board. At this juncture, the program manager reviewed the intervention curriculum with the peer promoters, and collectively they decided that the manual was "*too cold and bulky*"; as such, they revised the approach to the intervention to make it more client-friendly and culturally appropriate.

CHN then decided to hire an American peer promoter who proved to be both effective at outreach and acceptable to clients. In arriving at this decision, senior management and the program manager hypothesized that an American might be more effective in reaching Caribbeans because: (1) the Caribbeans would not feel that an American would know people that they knew; and (2) an American would likely be less hesitant to disclose his or her HIV status, so the problem of stigma would be greatly reduced. In the two sites that experienced the most turnover, CHN and Lutheran (see Table 6 on p.35), new peer promoters received a brief introduction to the program.

The original plan for sites that experienced turnover was that the peer promoter supervisor would meet with the new recruit to conduct an in-depth review of the multi-site training manual and the site-specific training materials (including the intervention manual), in an effort to bring the new peer promoter up to speed. Given that the original peer promoters received weeks—if not months—of training, it was assumed that review of the manual with the new recruit would involve several meetings between the recruit and the supervisor. Then, where appropriate and necessary, the new recruit might shadow an experienced peer promoter before working independently. However, the data indicate that, with the exception of Montefiore, this procedure was not followed in most cases of peer promoter turnover. In the two sites that experienced the most turnover, CHN and Lutheran (Table 6), new peer promoters received a brief introduction to the program. In some cases, they discussed the contents of the manuals. In other cases, they were told to review the manuals at home—and they started working after a brief orientation. Not surprisingly, fidelity to the intervention was compromised at these sites.

FIGURE 5

Miami CHIVES Intervention

Institutional Context:
Jackson Memorial Hospital, the only full-service provider for the uninsured and medically indigent in Miami-Dade County.

Staffing

a. Principal Investigator
- *Overall project direction*

b. Research Interviewer
- *In-reach, client follow-up*

c. Program Coordinator
- *In-reach, client follow-up*

d. Peer-promoter trainer/supervisor
- *Trained and supervised peer-promoters*

Partners

a. Hospital Case Management Department
- *Helped clients obtain Ryan White benefits*

b. Infectious Disease Department
- *Referred clients to the intervention*

c. Outpatient Clinic Administration
- *Facilitated clients' access to care*

d. Community Agencies
- *Provided Ancillary services*

2 Peer Promoters

Recruited from a cadre of volunteer peer educators already working at Jackson, who had completed at least 60 hours of volunteer work as a peer-promoter. Delivered the intervention – 5 one-on-one sessions during the 3 month enrollment period, conducted client follow-up, provided referrals and escort to healthcare and other appointments as well as reminder calls.

At times, clients forced departures from the intervention protocol. At CHN and Brookdale, clients were initially resistant to attending group sessions because of fear of disclosure. Therefore, at these sites, the group sessions had to be postponed. The peer promoters believed that the clients needed to tackle disclosure and stigma issues in a one-on-one setting before they were ready to engage in group discussions. At Brookdale, some clients never progressed to being ready for group discussions; in its place, the team instituted a separate session, held every two to three months, where these clients could meet socially without discussing HIV. The rationale for this approach was that the team believed that the clients could still derive some benefit from forming a social network that might, in time, lead to disclosure and mutual support among members.

TBALE 6

Peer Promoter Staff Turnover

	Brookdale	CHN	Lutheran	Miami	Montefiore
Peer promoters at start of program	11	4	4	2	4
Peer promoters as of August 2006	8	2	3	2	4
Highest # of peer promoters at any time as of August 2006	11	3	5	2	4
Longest-serving peer promoter (length of time served until August 2006)	36 months	8 months	36 months	25 months	36 months
Shortest-serving peer promoter (length of time served until August 2006)	5 months	1 months	3 months	25 months	14 months

Brookdale originally proposed a 12 to 18 month intervention, with decreasing intensity over time as clients became more skilled at navigating the system. The site believed 12 months was necessary to build a relationship with the client, such that (s)he would be able to achieve the program's objectives. When all of the sites convened for the first time in January 2004, Brookdale decided to reduce the length of its intervention to nine months to accommodate the research interview schedule that had interviews at baseline, three, six, and nine months. Then, in April 2005, after encountering challenges in outreach to and retention of clients, the site opted to shorten its intervention from 9 to 6 months as a means of keeping more clients engaged—since it was feared that the longer the intervention, the less likely clients would be retained.

Brookdale also changed the way that it conducted group sessions. Initially, its staff followed the intervention curriculum. However, the program coordinator and the peer promoter supervisor noticed that the groups did not understand the information. According to the program coordinator, "*they abandoned the curriculum's emphasis on theoretical concepts, such as 'positive living' and instead focus[ed] on practical issues—for example, how Magic Johnson lives and then tie in the concepts to the practical issue raised.*" They also allowed participants to determine what topics would be discussed. These changes resulted in more lively participation between the clients and the peers.

V. Conclusions/Lessons Learned

The four year period from 2003 to 2007 revealed many useful lessons learned and best practices for those wishing to replicate the CHIVES model. How to conduct outreach and recruitment in a hard-to-reach population beset by fears about stigma, immigration, and just the disease of HIV itself? What strategies work to retain clients in care? What staffing patterns facilitate the implementation process? These are a few of the questions that the CHIVES sites had prior to the intervention, and to which their experiences now provide some answers. In this section, lessons that were drawn from all sites—and/or would have had utility at all sites—are presented.

Stigma was the most intractable and pervasive challenge that the sites faced. It could not be ignored because *"stigma is killing people"*, as the Miami statistics illustrated. Stigma needed to be addressed in every aspect of the intervention, including the type of staff hired, the way outreach was conducted, the physical location of the intervention services, the hours of the intervention, the content of the intervention, and the approach to retaining peer staff and clients. Sites learned that their best intentions to fight stigma were sometimes rejected by prospective or current clients. This did not mean that these individuals could not be served, but rather that, service needed to be provided while acknowledging their feelings of stigma. Thus, for example, the decision was taken by some sites to alter their intervention curricula and not to require clients to meet in groups if they were uncomfortable doing so. Sites that had the most success with stigma let potential clients know upfront during outreach that stigma was a problem—and that the program was designed specifically to address issues of stigma.

It is important to note that stigma around HIV is nuanced, and may arise from multiple reasons. There is the stigma of contagion, of homosexuality, of social class, and of a host of other factors. Added to this, there is immigrant status in a context that, since 2001, has not been so welcoming of immigrants. Also, there is stigma related to country of origin, with some Haitians feeling particularly victimized because of the way Haiti was linked to HIV in the 1980s, and the way their countrymen who tried to immigrate to the United States were treated at that time. These are harsh realities facing some members of the immigrant population that could not be ignored or treated lightly by projects such as CHIVES.

Many of the sites were prepared for the clients to demonstrate feelings of stigma; however, some of the sites were caught off guard when peer promoters also fell in this category. This is a reminder that, although peer promoters may have been selected by virtue of the way in which they manage their HIV disease, they are peers—subject to the fears and emotions present within the target population. As one peer promoter observed, "*the only difference between us [peer promoters] and them is that we handle this [stigma] better and hopefully in a more healthy way.*" Sites that were not prepared to address peer promoters' concerns or, indeed, the concerns of any other HIV-positive team member, lost ground early in the Demonstration and then had a fight on their hands to regain it.

Finally, because stigma is so complex, there is no magic bullet; no easy fix. Talking about the resistance they encountered when trying to conduct outreach in the churches, the Montefiore principal investigator acknowledged, *"[we] assumed that sending Caribbean HIV related people to the churches would melt away resistance but this did not happen. What needs to happen is that the intervention has to grow from within the site of stigma."* In this regard, nearing the conclusion of the Demonstration, several sites were of the opinion that a community-wide campaign to provide education about stigma would have been a beneficial complement to the CHIVES behavioral intervention. In fact, Lutheran had proposed such an approach, but that was outside the purview of the Demonstration as conceived by HRSA.

Effective Outreach

Effective outreach was absolutely crucial to the success of the intervention. While CHIVES was not designed as an outreach initiative, the data show that it became one—partially because outreach had to be done to locate members of a population that, by and large, did not want to be found. Although all of the sites were experienced in serving the population, there was, perhaps, an underestimation of how hidden this population is—and returning to the issue of stigma, the effort needed to recruit even a few members.

It should be noted that where time is an issue, testing persons to find out their status is not the most effective outreach method. From a mathematical standpoint, in most cases the sheer number of persons that would need to be tested to net a reasonable sample of eligible clients is prohibitive. Furthermore, unless testing was conducted on the spot, the CHIVES sites' experience is that a considerable number of those who expressed initial interest in the intervention failed to follow-up at the clinic for their free test.

Many of the sites had outreach workers who also performed other tasks. That was perhaps not the most effective approach, because in order to reach the population, as one principal investigator observed, *"If you are doing outreach, you have to be dogmatic. You have to stay in their faces."* Outreach is not a part-time job; it must be done by trained, dedicated personnel. It has to employ creative tactics while taking stigma into account. Finally, it needs to be monitored closely so that approaches can be revised in response to the yield. Sites that followed these strategies tended to be more successful.

It is interesting that final interviews with the CHIVES team about their experiences with outreach revealed many creative ideas that could probably have made a dramatic difference in enrollment. When asked how they might approach outreach differently, sites provided the following suggestions of populations they would target:

- prisoners scheduled for release and return to the target community;
- participants in residential drug treatment programs;
- residents of homeless shelters; and
- prevention agencies not affiliated with the parent institution.

When asked why these approaches were not employed, the typical response was that no one thought of them. Thus, a lesson to be learned relative to outreach is that it must be creative. The community is constantly changing, and as a consequence, outreach efforts must adapt.

Time

Behavioral interventions, such as CHIVES, are very time consuming. Sites established time limits for their interventions, but all acknowledged that they ran out of time. Unanticipated challenges with outreach and other obstacles added to the time required to conduct the intervention. In addition, there was no way to predict which clients would have issues that would prevent them from adhering to the intervention schedule. As one peer promoter observed, *"things just cropped up."* Life events happen and often they are unexpected for patients who are coping with myriad personal issues, including HIV.

Time was not only an issue for clients but also for staff. One principal investigator advised that, "*time be set aside regularly for the team as a whole and in separate groups to reflect (not just report) on their work.*" Staff needed time to reflect on how they did their work so that they could make needed improvements. Being a peer is stressful and the CHIVES peer promoters who functioned most effectively took the time to renew their energies with the support of their managers.

Understand the Community

The CHIVES interventions reached into communities and sought to find clients. For such efforts to be successful, the CHIVES teams needed to understand their respective target communities. Understanding the community went beyond having knowledge of its problems and/or assets, to include willingness to engage the community, being visible in the community, and being responsive and accountable to the community. These efforts must be persistent. Montefiore provided a good example in this regard. From the outset its staff engaged the church community from which they were to recruit and sought the community's advice on the best outreach approach. The principal investigator stated that if she had to run the project again, she would invite the churches to provide even more input—extending to the intervention design and content. According to the principal investigator, "*The pastors they met were appropriately critical and were behind the project but could not translate the pastors' enthusiasm to the congregation. They would have been better served to ask pastors whom in their congregation wanted to design this project? This would have allowed the intervention to grow from within*" and would have honored the churches' expertise. Good community relations involve accountability. When the recruitment strategy did not seem to be working, the Montefiore team made adjustments and never abandoned the approach, but stuck with it until the end. The site kept abreast of what was happening in the community, which, like all immigrant communities, is constantly changing.

Sometimes understanding the community meant recognizing that it had a problem such as stigma or a lot of bureaucratic red tape (as was true for Miami, whose community was partly the large Jackson Hospital). Understanding the community also meant knowing whom the community respects, and therefore, whom one should select as a partner. CHN was particularly strong in this area. Finally, understanding the community required the sites to be inclusive, not exclusionary. Thus, the expansion of eligibility at three of the sites to include persons from many different countries helped dispel the notion that the projects were discriminatory.


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Flexibility

Given stigma, challenging outreach, and insufficient time—to mention just a few factors—flexibility is absolutely essential in the implementation of an intervention such as CHIVES. Without flexibility, the interventions would have become rigid exercises and missed their true goal. Where staff members were inflexible, things did not go well. For example, peer promoters whose personal schedules could not be altered to accommodate clients' needs missed encounters with those clients. Sites found that they had to make changes in their curricula, in their hours of operation, in their approach to outreach, in their timelines and in a host of other areas but the payoff was satisfied clients who were retained in the programs.

Strong Leadership

The preceding sections make the case for innovation, creative approaches, and flexibility. A strong leader is necessary to ensure that staff works in this manner. The de facto leaders of the CHIVES projects were the principal investigators, who were all involved to varying degrees in their respective projects. However, without exception, they had to delegate the day-to-day management to a strong leader who could provide the proper balance of oversight without micromanagement, particularly for the peer promoters. Projects seemed to run best when the principal investigators were kept abreast of what was going on so that, when necessary, they could address major problems and/or leverage institutional resources needed for the project.

Committed and Quality Staff

The quality of the staff was important at all of the sites. The most effective teams achieved a balance between staff with strong academic credentials and those with good hands-on experience. Both are needed in an intervention such as CHIVES. For example, someone on each team needed to know what the literature said about effective outreach to hard-to-reach populations so as not to repeat the mistakes of the past; someone else on the team needed to know how that research translated in the local community.

Teams with long-standing connections had a shared vision of the project, worked more cohesively, and solved problems faster. Small teams that shared a physical location tended to have more frequent communication, but Brookdale's experience with a large team shows that proactive scheduling of meetings can help a large team function well. Teams that worked most effectively provided each other with intra-group emotional support to prevent burnout and equalize workloads.

The need to be flexible means that working on an intervention such as CHIVES is not a 9-to-5 job. This calls for commitment at all levels. Peer promoters at all sites put in long hours—in many cases in excess of what they were contractually required to work. Sites that reported the most success also reported that team members shared the same levels of commitment, with other members of the team working equally as long and hard as the peers.

The peer promoter job descriptions from the various sites enumerate a laundry list of skills, attributes, and capacities that a peer promoter should have. At the same time, commonalities across all sites were sensitivity, flexibility, dedication, empathy, strong connection to the community, and ability to maintain confidentiality. There was disagreement on whether an effective peer promoter had to be comfortable with disclosure of his or her HIV status. Some sites stressed this aspect. Others let the peer promoters decide if, when, and where they would disclose their status.

Treatment of Peer Promoters

In order to be effective and find satisfaction in their assignments, peer promoters needed to be treated as professionals on a par with the rest of the project staff. This means that they needed to be paid a living wage. The site at which the peer promoters reported the least problems with the issue of compensation paid them starting on the first day of the training that preceded the intervention launch. Peer promoters also wanted to be addressed professionally, and be able to provide input into the design and implementation of the interventions that they were asked to deliver. For peers to feel that they were treated as professionals, the respect they received could not be limited to just the immediate team members, but needed to come from other providers in the institution. Herein lay a challenge, and a responsibility for the team leader, to persuade and motivate providers who typically did not view peers as professionals to adopt such views.

FIGURE 6

Montefiore CHIVES Intervention

Institutional Context:
The Women's Center, an autonomous division of Montefiore Medical Center that provides holistic care to HIV+ persons in Bronx, NY.

Staffing

a. Principal Investigator
- *Overall project direction*

b. Medical Director/Pastor
- *Liaison with program & clinical services*
- *Assisted with church outreach*

c. Clinical Social Worker
- *Clinical social work services to clients*
- *Ran group facilitators meetings for peer-promoters*

d. Research Interviewer
- *Client follow-up and administrative tasks*

e. Peer-Promoter Supervisor
- *Trained and supervised peer-promoters*

Partners

a. Montefiore AIDS Center
- *Client referrals*

b. Local public clinic
- *Client referrals*

c. Local testing and counseling sites
- *Client referrals*

4 Peer Promoters

Recruited based on recommendations from the staff at the Montefiore AIDS Center and the Women's Center clinic.
Conducted outreach, client follow-up, delivered the intervention – weekly one-on-one sessions for the entire enrollment period of 12 months; weekly group sessions for 12 months; provided referrals and escort to healthcare and other appointments as well as reminder calls.

Peer promoters needed to be supported—not just in words—but actively, so that they could set boundaries with clients, pay attention to their own health care needs, receive up-to-date and ongoing training, and for some, fight the battle against stigma. According to the CHIVES peer promoters, it was important to perceive that they had the support of the project management team. Such support was evident by training opportunities that were provided, the availability of support groups to enable the peers to cope with their responsibilities, and an overall conscious acknowledgement on the part of managers that the peer promoters had needs that should be addressed.

Resources

Interventions such as CHIVES cost money. When the underserved—or those with no services—start receiving services, costs automatically increase. The CHIVES interventions were no exception. Costs increase even more over time as clients begin to understand their rights and push for more services. All of the sites reported that there was critical need for funding to pay for ancillary services, such as transportation, housing assistance, and food banks. There were the unanticipated costs of outreach as well. Case-management services also required resources. Insufficient funding hampered the work and made site staff less effective than they otherwise might have been.

Work Smart

All of the sites worked hard but some were better at analyzing what they were doing and making needed changes so that they were able to work smart. At each site, the context in which the intervention was operating was constantly changing, requiring ongoing adaptation by staff.

Working smart meant data-driven decision making; for example, obtaining HIV surveillance statistics on the target population so that a site would know where best to conduct outreach. Planning ahead and having contingency plans, such as a procedure to handle the departure of a peer promoter, helped to avoid sudden crises. Similarly, spending time upfront carefully designing the curriculum, testing it, refining it, and ensuring that the staff was trained to use it saved some sites many headaches during implementation.

Addressing Clients' Priorities

Clients presented with a variety of needs, and in order to engage and retain them the peer promoters were required to not only respond to the needs, but also to the priority needs as identified by the clients. The staff had to understand that for some clients their HIV disease was not a priority, given what else might have been going on in their lives. In order to adopt this mode of thinking, peer promoters had to demonstrate empathy, sincerity, and insight to determine what clients really felt—as opposed to what they might have been saying. It was also important to give clients a sense that they were being helped and that their problems were being addressed by the program without being patronizing. Finally, peer promoters should never give the impression that they are losing hope in clients because, as one supervisor said, *"I have seen people [clients and peers] come in here crying, without hope, broken and now they blossom and shine. They have gone back to work, planned weddings, and helped deliver babies."*

Building Trust

Trust was important to break down barriers erected by stigma and confidentiality concerns. Cultural competency and concordance helped to forge bonds of trust between the peer promoters and their clients. Time was also a factor, and for some peer promoters, willingness to disclose helped immensely. The sites' experiences indicate that in order to foster and maintain trust it is important to stress repeatedly that confidentiality is being maintained. Mentioning this at the time of enrollment is not enough because, for many clients, concerns around this issue are only allayed temporarily before being resurrected again by any manner of incident.

Appropriate Physical Space

Appropriate locations for the CHIVES interventions made clients feel safe and comfortable. Space has strong cultural meaning in the Caribbean. Sites that provided clean, comfortable, and most important of all—anonymous space—sent a message that clients were valued and welcome. To provide true anonymity and address stigma and related confidentiality concerns, space needed to be completely devoid of any reference to HIV or AIDS. In addition, office space for peer promoters needed to be private so encounters could be kept confidential. As in the case of Montefiore, where their space was also made homey and inviting, chances were that clients would want to "*hang out*" there. This was one way of attracting them and ensuring that they remained connected to the program.

Institutional Support

Institutional support is listed last, though not because it is unimportant; to the contrary, it is the very foundation of a successful intervention. Sites found that their parent institutions had to be on board philosophically in terms of being committed to providing care to the uninsured and otherwise disadvantaged. If they were not, the site did not have the necessary support at all levels. Sites fortunate enough to have solid institutional support were able to have their programs well integrated into the institutions. This facilitated inter-departmental referrals.

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